MOBILIZATION

PERSONAL INJURY NOTICE

Fax Copy of Medical Unit Report, Personnel Time Report and this Notice

To EMD Risk Manager at (253) 512-8497 within 24 hours of Incident

Resource #
Event Name:

TO BE COMPLETED AT TIME OF INJURY / EXPOSURE BY INDIVIDUAL OR SUPERVISOR

Name:	Sex: Male / Female	DOB:
Mailing Address:	Number you can be reached at:	
City:	State:	ZIP:
Fire Jurisdiction:	FDID #	
Person Completing Form:	Date:	

Notice Type: ☐ INJURY ☐ EXPOSURE		Date of Incident:	
Time : (AM) (PM)	Work Hours: (AM) (PM) to: (AM) (PM)		On Duty: (YES) (NO)
Location of Incident:			
Description of Incident:			
Describe Extent of Injuries / Exposure:			
Did You Receive Medical Treatment at Time of Injury?	YES	NO	Location:
Did You Receive Additional Medical Treatment?	YES	NO	Facility:
Has a Labor & Industries Claim Been Filed By You?	YES	NO	Claim #:
Was a Third Party Involved in Your Injury / Exposure?	YES	NO	Identify below
Third Party Name:			Phone:
Address:	City:		State: ZIP:
Witness:			Phone:
Name of Person Knowledgeable of Injury:			**Phone:**

Reviewer	Printed Name	Signature	Date
Immediate Supervisor:			
Division Supervisor:			
Medical Unit Leader:			
Safety Officer:			

Safety Officer Section
List Attachment of Forms Completed Regarding This Injury / Exposure: Attach Additional Sheets As Necessary.

Return To:
WSP Emergency Mobilization Section
POB 42600
Olympia, WA 98504

Top Copy: To Mobilization Section
Second Copy: To Incident
Third Copy: To Jurisdiction / Employee

MOBE 4-2 Effective 5/02
Do Not Use Previous Versions